Healthy Arkansas, Inc.
PO Box 21388
Eagan, MN 55121
1-844-325-0275 TTY: 711

## Provider Attestation for SSBCI Eligibility

Special Supplemental Benefits for the Chronically Ill (SSBCI) are supplemental benefits for members that have one of more of the following conditions:

- Chronic alcohol and other drug dependence
- Autoimmune disorders
- Cancer
- Cardiovascular disorders
- Chronic heart failure
- Dementia
- Diabetes
- End-stage liver disease
- End-stage renal disease (ESRD)
- Severe hematologic disorders
- HIV/AIDs
- Chronic lung disorders
- Chronic and disabling mental health conditions,
- Neurologic disorders
- Stroke
- Overweight, obesity, and metabolic syndrome
- Chronic gastrointestinal disease
- Post-organ transplantation
- Immunodeficiency and Immunosuppressive disorders
- Conditions associated with cognitive impairment
- Conditions with functional challenges, chronic conditions that impair vision, hearing (deafness) taste, touch, and smell
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning.

Please complete this form attesting that the patient has one or more of the conditions above. Then fax the completed form to 501-498-7411 or mail it to:

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**Patient Information:**

First Name:_____ Last Name:_____ MI:____

Member ID: _____ Date of Birth:_____

Phone:_____

Address:_____
_____

City:_____ State: _____ Zip Code:_____

**Provider Attestation:**

□ My records for the above-named patient document one of the diagnoses for a chronically ill individual who has one or more of the chronic conditions listed below and meets all of the following criteria:

1. is life threatening or significantly limits the overall health or function of the enrollee
2. has a high risk of hospitalization or other adverse health outcomes
3. requires intensive care coordination

Chronic Conditions:
□ Chronic alcohol and other drug dependence □ Autoimmune disorders □ Cancer
□ Cardiovascular disorders □ Chronic heart failure □ Dementia □ Diabetes □ Stroke
□ End-stage liver disease □ End-stage renal disease (ESRD)
□ Severe hematologic disorders □HIV/AIDS □ Chronic lung disorders
□ Chronic and disabling mental health conditions □ Neurologic disorders
□ Overweight, obesity, and metabolic syndrome □ Chronic gastrointestinal disease
□ Post-organ transplantation □ Immunodeficiency and Immunosuppressive disorders
□ Conditions associated with cognitive impairment
□ Conditions with functional challenges, chronic conditions that impair vision, hearing (deafness) taste, touch, and smell
□ Conditions that require continued therapy services in order for individuals to maintain or retain functioning.
□ My records for this patient do not include a diagnosis of any of the above conditions and/or patient is not at high risk of hospitalization of other adverse outcomes.
I hereby attest that the information selected above is correct and is noted in the patient's medical record.

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Provider Name (please print):
_____

Provider Credential:
_____

Provider NPI#_____

Provider
Signature:_____

Date:_____

Phone:_____ Fax:_____

Address:_____

City:_____ State:_____ Zip
Code:_____